CalPolyPomona

STUDENT HEALTH & WELLNESS SERVICES

California State Polytechnic University, Pomona

Authorization to Consent to Medical Treatment for Minors

Bronco ID: _____

The undersigned parent/guardian/authorized agent of _____
(Student Name)

authorizes a California State University, Pomona Student Health and Wellness Services Staff as agent for the undersigned, to consent to any medical or surgical treatment, x-ray, anesthesia or hospital care that is deemed advisable, and is to be provided by any clinicians licensed under the provisions of the Medical Practice Act for any injury or illness until this minor is 18 years of age. The diagnosis or treatment may be provided at the office of the clinician or at a hospital.

This authorization is given in advance of any specific diagnosis, treatment or hospital care being required. It is given to provide authority to the above-named agent to give consent for diagnostic test, treatment or hospital care that a clinician may deem advisable. The undersigned authorizes any medical facility, which has provided treatment to the minor, to surrender physical custody of the minor to the agent upon the completion of treatment.

_____
Parent, Guardian or Authorized Agent Signature Date

_____
Print Name Relationship

( ) _____ ( ) _____
Primary phone Number Secondary Phone Number

Minor Student Birthdate: _____ Date of last Tetanus/Tdap Booster:_____

Allergies to medication:_____

Insurance Carrier: _____ Policy# _____

For Student Health Services Use Only

Telephone consent to treat above-named minor given by_____
Name and Relationship to Patient

To_____
Student Health Service Staff Date

Authorized Agent Consenting for Medical Treatment- SHS Staff Only

_____
Signature of Authorized Agent Date

_____
Signature of Authorized Agent Date